Minnesota Board of Marriage and Family Therapy
2829 University Avenue SE, Suite 400
Minneapolis, MN 55414-3222
Telephone: (612) 617-2220 Fax: (612) 617-2221
Email: mft.board@state.mn.us Website: www.bmft.state.mn.us
Hearing Impaired-Minnesota Relay Service: 1-800-627-3529

Application for LMFT Licensure by Reciprocity

Instructions:

*In order to be licensed by reciprocity in the State of Minnesota, you must hold a *current* LMFT license in a state whose licensure requirements meet or exceed the current requirements for licensure in Minnesota.

*Licensure by reciprocity applies *only* to those individuals who have passed the National Examination in MFT promulgated by the Association of Marriage and Family Therapy Regulatory Boards. If you were licensed as a LMFT in a jurisdiction or at a time where passage of the National Exam in MFT was not required, please contact the Board for information on how to proceed with your application for licensure.

1. Type all answers or print in black ink. Complete all sections. If a section is not applicable, enter N/A in the space provided.

2. If additional response information is required for any question, please attach a separate sheet of paper. Identify the question to which the answer applies and include **your printed name and signature on each page**.

3. A transcript covering all graduate work used to meet educational requirements for licensure (listed on page 3) must be sent directly to the Board from the academic institution(s). The application will not be processed without the required transcript(s).

4. Applicant's signature and notarization of pages 6 and 7 is required.

5. Section III of this application requires the licensing board(s) in the state(s) in which you currently hold the LMFT license, or have held LMFT license, to submit license verification directly to the Minnesota Board. Make copies of this verification form as needed and provide to the appropriate licensing board(s).

6. Attach a check payable to "**MN Board of MFT**" for the application fee of **$220.00**. All fees are nonrefundable.

7. Mail this application to the address listed above. Keep a copy of all documents submitted to the Board.

8. If your application for licensure is approved, you will be notified electronically, and the state licensure (oral) examination with the Board will be scheduled within 60 days of notification of application approval. Upon successful completion of the oral examination, you will be required to remit the annual LMFT licensing fee of $125.00, which will be prorated, depending upon the month you are approved for licensure.

This document is available in alternative formats to individuals with disabilities by calling (612) 617-2220, or, through the Minnesota Relay Service at (800) 627-3529.

Office Use Only: Check#:_____ Amount: $_____ Deposit #:_____

Rights of Subject of Data: Information you provide as an applicant, except for your name and address, is classified as private while you remain an applicant; that is, accessible only to you, the staff and members of the Board, the Board's counsel, and persons you designate. When you become licensed, the information in your file related to your licensure is classified as public. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. You are not legally required to provide this information, but you cannot be licensed without doing so.

Tax Clearance Information (Minn. Stat. 270C.72): The Board is required to provide to the MN Department of Revenue your social security number. Upon request of the Commissioner of Revenue, the Board must provide to the Commissioner a list of all regulated individuals and applicants, including their names and addresses, social security numbers, and business identifications numbers. (1) This information may be used to deny the issuance or renewal of your license in the event you owe the Minnesota Department of Revenue delinquent taxes in the amount of $500.00 or more. (2) Upon receiving this information, the Board will supply it only to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Agreement, the Department of Revenue may supply this information to the Internal Revenue Service. (3) Failure to supply this information may prevent or delay the processing of your application.

Tennessen Warning (Minn. Stat. 13.04): Data collected under "Ethical Qualifications" is confidential/non-public and may be used for investigative purposes. The Board is seeking data from you which may be considered private or confidential under the Minnesota Government Data Practices Act, Minn. Stat. 13.01 et seq. Minn. Stat. 13.04, subd. 2 requires the Board to notify you of the following four matters before you are asked to supply such information about yourself: (1) This data is being collected to determine whether you meet the requirements for licensure as well as whether you have violated any statutes or rules the Board is empowered to enforce; (2) You are not legally required to complete and return this application, but failure to do so may result in the denial of this application; (3) If you supply the data requested and it shows a violation of any of the statutes or rules enforced by the Board, you may be subject to disciplinary or other action by the Board. If you refuse to supply the data requested, your application may be denied. In addition, falsification or omission of information may be used by the Board as a basis for disciplinary action; and (4) The data which you supply will be accessible to Board staff. The data you supply may also be released to other persons and/or governmental entities that have statutory authority to review the data, investigate specific conduct, and/or take appropriate legal action. If the Board institutes a formal disciplinary action against you, the information you supply could become public.

APPLICATION FOR LMFT LICENSURE BY RECIPROCITY

Section I - Applicant Information

NAME: Last First Middle	
SOCIAL SECURITY #:	**DATE OF BIRTH** (mm/dd/yyyy):
SEX: ☐ **Male** ☐ **Female**	**Are you a U.S. Citizen:** ☐ **Yes** ☐ **No*** (*If no, attach copy of documentation verifying right to work status in U.S.)
PUBLIC ADDRESS: (Street Address)	(City) (State) (Zip Code)
MAILING ADDRESS: (Street Address) If same as public address, check here ☐	(City) (State) (Zip Code)
***PRIMARY BUSINESS OR AGENCY NAME:**	
BUSINESS ADDRESS: (Street Address)	(City) (State) (Zip Code)
EMAIL (please print clearly/for Board use only):	
TELEPHONE: (At least one number is required.) Business: Home: Cell:	
Designated phone number for release to Public: ☐ **Business** ☐ **Home** ☐ **Cell**	

***Important:** Applicants must provide a primary business address at time of initial application and all subsequent license renewals. Your primary business address is public. If you are not currently in the workforce related to mental health practice, write "Not Working" in the primary business address section above. *See* Minn. Stat. 214.073**.**

Office Use Only: Check#:_____ Amount: $_____ Deposit #:_____

Applicant Graduate Education:

Provide information regarding all graduate education used to meet the educational requirements for licensure in the jurisdiction where you hold the LMFT license. Transcripts from these institutions must be sent directly to the MN Board by the graduate institution. Only education from a regionally-accredited institution can be used to meet licensure requirements.

Name of Graduate Institution	Location (City, State)	Degree Obtained and Field of Study	Date Degree Granted Month/Year

Applicant Licensure Status:

Provide information regarding all health-related licenses you hold or have held (current and expired).

State of Licensure	Title of License	License Number	Date Issued	Expiration Date

Applicant Membership Status:

Provide information regarding all current memberships in any mental health-related professional organizations.

Name of Professional Organization	Type/Name of Membership	Years of Membership

Section II - Ethical Qualifications

If you answer "Yes" to any question, you **must include** a signed, written explanation and provide any relevant documents. Answering "Yes" to certain questions may require special screening or review procedures by the Board. Failure to disclose requested information or a false answer to any question may result in denial of your renewal or other appropriate Board action.

Y ___ N ___	1. Have you been convicted, pled guilty or pled no contest to a misdemeanor, gross misdemeanor or felony, or have criminal charges been filed against you? Include traffic offenses where the charge involves the use of alcohol or drugs even if the final conviction or plea is not related to the use of alcohol or drugs.
Y ___ N ___	2. Have you been found to be in violation of a professional association's code of ethics, or of a state licensing board's rules, regulations or statutes regarding professional conduct?
Y ___ N ___	3. Have you been investigated, sanctioned or disciplined by a professional association or state licensing board?
Y ___ N ___	4. Do you hold or have you ever held a license, certificate or registration to practice marriage and family therapy or any other health-related profession in MN or any other jurisdiction which has been revoked, suspended or otherwise had action taken against it for any reason?
Y ___ N ___	5. Have you voluntarily surrendered any professional license or registration issued by a professional association or state licensing board, or allowed a license or professional registration to lapse, while a complaint was pending against you with the professional association or state licensing board?
Y ___ N ___	6. Have you had an application denied, or been denied membership or licensure by any professional association or state licensing board?
Y ___ N ___	7. Have you been subjected to disciplinary action by a post-secondary educational institution, withdrawn from a post-secondary educational institution or been investigated by a post-secondary educational institution, because of alleged misconduct of any kind?
Y ___ N ___	8. Have you been named as a party to any civil litigation, arbitration, mediation or a malpractice action related in any way to your profession?
Y ___ N ___	9. Are you currently unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals or any other materials, or as a result of any mental, physical or psychological condition?
Y ___ N ___	10. Do you participate in any program, other than the State of Minnesota's Health Professional Services Program (HPSP), designed to monitor or assist you in the management of a chemical dependency, physical, psychological or emotional impairment?
Y ___ N ___	11. Do you currently have any other condition or impairment, not reported in any question in this application, which in any way affects, or if left untreated might affect, your ability to practice marriage and family therapy with reasonable skill and safety to clients?

Affirmation of Applicant

Attention: Please read the following paragraphs carefully before signing this application:

STATE OF (where notarized) _____)

COUNTY OF (where notarized)_____)

I, _____ *(print name of applicant),* **hereby apply for the LMFT license, under the laws and regulations governing marriage and family therapy licensure in Minnesota, and certify under penalty of perjury that all statements contained herein are true and correct to the best of my knowledge and belief; and that I am the person named in the credentials submitted, and the same were procured in the regular course of instruction, without fraud or misrepresentation; with full knowledge that all statements made in this application may be subject to investigation; and that any false or dishonest answers to any questions in the application may be grounds for refusal, or subsequent revocation or suspension, of my license.**

I hereby acknowledge I have reviewed Minnesota Statutes, Sections 148B.01 to 148B.1751 and 148B.29 to 148B.39, and administrative rules promulgated by the Board of Marriage and Family Therapy. I understand that I am under a continuing obligation to keep informed of any changes to the law and rules governing marriage and family therapy licensure.

I hereby affirm that I have read the Code of Ethics adopted by the State of Minnesota Board of Marriage and Family Therapy. I agree to conduct all professional activities as a licensed marriage and family therapist in accordance with the Code of Ethics adopted by the Board.

_____
Signature of Applicant

Subscribed and sworn to before me this _____ day of _____ 20_____

_____
Signature of Notary Public

My commission expires: _____ Notary Seal

Certification of Identification To Be Completed by Notary Public

Certification of Notary Public is required.

Applicant Name: _____

Applicant Signature: _____

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photography affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

Sworn to before me by the applicant

On this _____ day of _____ , 20_____

Signature of Notary Public _____

My commission expires: _____

Notary Seal :

Paste a recent photo, front-view passport-type photo in this square

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Section III – Verification of Licensure in Other Jurisdiction – Page 1 of 2

DIRECTIONS TO RECIPROCITY APPLICANT: Complete Part I and forward to the State board(s)/office(s) where you hold or have held a license to practice Marriage and Family Therapy. **Make copies as needed** for verification from more than one licensing jurisdiction.

PART I-TO BE COMPLETED BY THE RECIPROCITY APPLICANT

Name of Applicant	State of License Issuance	License No.	Date Issued	Expiration Date

I was granted a license as described above and request that verification of that license be submitted to the Minnesota State Board of Marriage and Family Therapy. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Minnesota Board. Your prompt attention is requested.

_____

LMFT Signature **Date**

PART II-TO BE COMPLETED BY THE STATE BOARD VERIFYING LICENSURE (Please complete this form and return it to the address indicated on page 2. In lieu of completing the supervision verification boxes, you may attach copies of any verification of supervision or supervised experience forms filed as part of the application for LMFT licensure in your jurisdiction.

Name of Licensee	Licensure Type	License No.	Date Issued	Expiration Date
Exam Taken _____ **AMFTRB** ____ **Other (specify)**_____		**Date Exam Passed**		**Exam Score**
State MFT Practice Act or Administrative Rule/Code Citation:				

Hours of supervision and direct supervised clinical experience required for licensure:

Total hours of direct clinical services (all therapy hours including individual and couple/family therapy): _____

Total hours of direct clinical services to couples and families: _____

Total hours of supervision (all supervision hours including individual and group supervision):_____

Total hours of individual supervision: _____

Is LMFT licensure required for an individual to serve as a supervisor for purposes of licensure: Yes_____ No _____
If No, what license credential may a supervisor hold? _____

Verification of Licensure in Other Jurisdiction – Page 2 of 2

Please Verify Supervision Requirements Met in Your Jurisdiction
Supervision dates: From ___________ to ___________
Clinical Supervisor: _____________________________________ License Type & #: _______________________________
Total hours of supervision: _________ Number of hours of individual supervision:______________
Total hours of supervised clinical services: ________
Number of hours of supervised clinical services to couples and families: __________

Please Verify Supervision Requirements Met in Your Jurisdiction
Supervision dates: From ___________ to ___________
Clinical Supervisor: _____________________________________ License Type & #: _______________________________
Total hours of supervision: _________ Number of hours of individual supervision:______________
Total hours of supervised clinical services: ________
Number of hours of supervised clinical services to couples and families: __________

Please Verify Supervision Requirements Met in Your Jurisdiction
Supervision dates: From ___________ to ___________
Clinical Supervisor: _____________________________________ License Type & #: _______________________________
Total hours of supervision: _________ Number of hours of individual supervision:______________
Total hours of supervised clinical services: ________
Number of hours of supervised clinical services to couples and families: __________

Disciplinary or Public Action(s): _______ **Yes*** ________ **No**

***Explain Disciplinary or Public Actions. Attach copies of all public orders:**

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Board Seal of State
Board Verifying Licensure

____

Signature **Date**

Name (please type or print)	Title	Telephone No.

Mail To:
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Minneapolis, MN 55414